12. Razavi D, Delvaux N, Marchal S, et al. Does training increase the use of more emotionally laden words by nurses when talking with cancer patients? A randomised study. *Br J Cancer.* 2002;87(1):1–7.
13. Brown RF, Butow PN, Boyle F, Tattersall MH. Seeking informed consent to cancer clinical trials; evaluating the efficacy of doctor communication skills training. *Psychooncology.* 2007;16(6):507–516.
14. Parker PA, Baile WF, de Moor C, Lenzi R, Kudelka AP, Cohen L. Breaking bad news about cancer: patients' preferences for communication. *J Clin Oncol.* 2001;19(7):2049–2056.
15. Mystakidou K, Parpa E, Tsilila E, Katsouda E, Vlahos L. Cancer information disclosure in different cultural contexts. *Support Care Cancer.* 2004;12(3):147–154.
16. Hagerty RG, Butow PN, Ellis PM, Dimitry S, Tattersall MH. Communicating prognosis in cancer care: a systematic review of the literature. *Ann Oncol.* 2005;16(7):1005–1053.
17. Hancock K, Clayton JM, Parker SM, et al. Discrepant perceptions about end-of-life communication: a systematic review. *J Pain Symptom Manage.* 2007;34(2):190–200.
18. Clayton JM, Butow PN, Arnold RM, Tattersall MH. Fostering coping and nurturing hope when discussing the future with terminally ill cancer patients and their caregivers. *Cancer.* 2005;103(9):1965–1975.
19. Hagerty RG, Butow PN, Ellis PM, et al. Communicating with realism and hope: incurable cancer patients' views on the disclosure of prognosis. *J Clin Oncol.* 2005;23(6):1278–1288.
20. Clayton JM, Hancock KM, Butow PN, et al. Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers. *Med J Aust.* 2007;186(Suppl 12):S77, S9, S83-S108.
21. Brown RF, Brown R, Bylund CL, Eddington J, Gueguen JA, Kissane DW. Discussing prognosis in an oncology setting: Initial evaluation of a communication skills training module. *Psycho-oncology.* 2009;PMID:19441006.
22. Brown RF, Butow PN, Butt DG, Moore AR, Tattersall MHN. Developing ethical strategies to assist oncologists in seeking informed consent to cancer clinical trials. *Soc Sci Med.* 2004;58:379–390.
23. Brown RF, Butow PN, Ellis P, Boyle F, Tattersall MH. Seeking informed consent to cancer clinical trials: Describing current practice. *Soc Sci Med.* 2004;58(12):2445–2457.
24. Charles C, Gafni A, Whelan T, O'Brien MA. Cultural influences on the physician-patient encounter: The case of shared treatment decision-making. *Patient Educ Couns.* 2006;63(3):262–267.
25. Hahn SR, Kroenke K, Spitzer RL, et al. The difficult patient: prevalence, psychopathology, and functional impairment. *J Gen Intern Med.* 1996;11(1):1–8.
26. Philip J, Gold M, Schwarz M, Komesaroff P. Anger in palliative care: a clinical approach. *Intern Med J.* 2007;37(1):49–55.
27. Gueguen JA, Bylund CL, Brown RF, Levin TT, Kissane DW. Conducting Family Meeting in Palliative Care: Themes, Techniques and Preliminary Evaluation of a Communications Skills Module. *Palliat Support Care.* 2008;7(2):171–179.
28. Dumont I, Kissane D. Techniques for framing questions in conducting family meetings in palliative care. *Palliat Support Care.* In press.
29. Kissane D, Gueguen J, Bylund C, Brown R, Levin T. Conducting family meetings in palliative care: themes, techniques and preliminary evaluation of a communication skills module. *Palliat Support Care.* In press.
30. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA.* 2000;284(19):2476–2482.
31. Schofield P, Carey M, Love A, Nehill C, Wein S. 'Would you like to talk about your future treatment options'? Discussing the transition from curative cancer treatment to palliative care. *Palliat Med.* 2006;20(4):397–406.
32. Parker SM, Clayton JM, Hancock K, et al. A systematic review of prognostic/end-of-life communication with adults in the advanced stages of a life-limiting illness: patient/caregiver preferences for the content, style, and timing of information. *J Pain Symptom Manage.* 2007;34(1):81–93.
33. Baile WF, Kudelka AP, Beale EA, et al. Communication skills training in oncology. Description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. *Cancer.* 1999;86(5):887–897.
34. Bylund CL, Brown RF, di Ciccone BL, et al. Training faculty to facilitate communication skills training: development and evaluation of a workshop. *Patient Educ Couns.* 2008;70(3):430–436.
35. Fryer-Edwards KA, Arnold RM, Baile WF, Tulsky JA, Petracca F, Back AL. Reflective teaching practices: An approach to teaching communication skills in a small-group setting. *Acad Med.* 2006;81(7):638–644.
36. Bylund CL, Brown RF, Lubrano di Ciccone B, Diamond C, Eddington J, Kissane DW. Assessing facilitator competence in a comprehensive communication skills training programme. *Med Edu.* 2009;43:342–349.
37. Kurtz S, Silverman J, Draper J. *Teaching and learning communication skills in medicine.* Radcliffe, Abingdon: Medical Press Ltd; 1998.
38. O'Connor AM, Stacey D, Entwistle V, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev.* 2003;(2):CD001431.
39. Juraskova I, Butow P, Lopez A, et al. Improving informed consent: pilot of a decision aid for women invited to participate in a breast cancer prevention trial (IBIS -II DCIS). *Health Expect.* 2008;11(3):252–262.
40. Brown RF, Butow PN, Butt DG, Moore AR, Tattersall MHN. Developing ethical strategies to assist oncologists in seeking informed consent to cancer clinical trials. *Soc Sci Med.* 2004;58:379–390.
41. Basch EM, Thaler HT, Shi W, Yakren S, Schrag D. Use of information resources by patients with cancer and their companions. *Cancer.* 2004;100(11):2476–2483.
42. Metz J, Devine P, DeNittis A, et al. A multi-institutional study of internet utilization by radiation oncology patients. *Int J Radiat Oncol Biol Phys.* 2003;56(4):1201–1205.
45. Monnier J, Laken M, Carter CL. Patient and caregiver interest in internet-based cancer services. *Cancer Pract.* 2002;10(6):305–310.
44. Ranson S, Morrow GR, Dakhil S, et al. *Internet use among 1020 cancer patients assessed in community practice: A URCC CCOP study. Proc Annu Meet Am Assoc Cancer Res.* 2003;22:534.
45. Makoul G. Perpetuating passivity: reliance and reciprocal determinism in physician-patient interaction. *J Health Commun.* 1998;3(3):233–259.
46. Bylund CL, Sabee CM, Imes RS, Sanford AA. Exploration of the construct of reliance among patients who talk with their providers about internet information. *J Health Commun.* 2007;12(1):17–28.
47. Helft PR, Hlubocky F, Daugherty CK. American oncologists' views of Internet use by cancer patients: a mail survey of American Society of Clinical Oncology members. *J Clin Oncol.* 2003;21(5):942–947.
48. Broom A. Medical specialists' accounts of the impact of the internet on the doctor/patient relationship. *Health.* 2005;9(3):319–338.
49. Newnham G, Burns W, Snyder R, et al. Attitudes of oncology health professionals to information from the Internet and other media. *Med J Aust.* 2005;183(4):197–200.
50. Bylund CL, Gueguen J. The effect of internet use on the doctor-cancer patient relationship. In: Kissane D, Butow P, Bultz B, (eds). *Handbook of communication in cancer and palliative care.* Oxford: Oxford University Press; in press.
51. Parker PA, Davison BJ, Tishelman C, Brundage MD. What do we know about facilitating patient communication in the cancer care setting? *Psychooncology.* 2005;14(10):848–858.
52. Street R. Communication in medical encounters: an ecological perspective. In: Thompson T, Dorsey AM, Miller KI, Parrott R, (eds). *Handbook of health communication.* Mahwah, NJ: Lawrence Erlbaum Associates; 2003.
53. Roter DL, Stewart M, Putnam SM, Lipkin MJ, Stiles W, Inui TS. Communication patterns of primary care physicians. *JAMA.* 1997;277(4):350–356.
54. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: Have we improved? *JAMA.* 1999;281(3):283–287.
55. Bylund CL, Makoul G. Examining empathy in medical encounters: an observational study using the empathic communication coding system. *Health Commun.* 2005;18(2):123–140.
56. Chewning B, Wiederholt JB. Concordance in cancer medication management. *Patient Educ Couns.* 2003;50(1):75–78.
57. Cegala DJ. Communication skills training for patients: Implications for research into message production in primary care settings. San Francisco: ICA; 1999.
58. Cegala DJ, Marinelli T, Post D. The effects of patient communication skills training on compliance. *Arch Fam Med.* 2000;9(1):57–64.
59. Cegala DJ, McClure L, Marinelli TM, Post DM. The effects of communication skills training on patients' participation during medical interviews. *Patient Educ Couns.* 2000;41(2):209–222.
60. Bylund C, D'Agostino T, Chewning B. Training patients to reach their communication goals: a concordance perspective. In: Kissane D, Bultz B, Butow P, Finlay I, (eds). *Handbook of communication in oncology and palliative care.* Oxford: Oxford University Press; 2009.

CHAPTER 87

Education of Chaplains in Psycho-Oncology

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INTRODUCTION

Ministering to the needs of the sick has been a central role of clergy of different faiths for centuries. In the United States, modern healthcare chaplaincy began in 1924 with the appointment of clergyman Anton Boisen as chaplain at a psychiatric hospital in central Massachusetts.[1] The next summer Boisen led a training program for four theological students. In 1930 an organization was formed to promote programs, such as Boisen's, to give theological students experience in supervised care for people in crisis.[2] These training programs came to be called clinical pastoral education (CPE).

In 1939, Russell Dicks, an early hospital chaplain and CPE supervisor, made a presentation on the work of chaplains to the annual meeting of the American Protestant Hospital Association (APHA).[3,4] Dicks' speech moved the APHA to appoint a committee to formulate standards for hospital chaplaincy. The new standards, which the APHA adopted the following year, addressed issues of chaplains' accountability, interdisciplinary collaboration, selection of patients, record keeping, and training. At the APHA meeting in 1946 a group of chaplains active in APHA hospitals formed the Association of Protestant Hospital Chaplains, one of the first organizations of professional healthcare chaplains in the United States.[4,5]

In the rest of this chapter we provide an introduction to healthcare chaplaincy. We begin with a general overview of who healthcare chaplains are, their training, where they work, and what they do. Then we describe healthcare chaplains' work caring for patients with cancer, including their work in hospice and palliative care. These descriptions are largely based on the U.S. context. However, in the following section we describe the training and work of healthcare chaplains in Europe. In the final section we briefly describe future directions for healthcare chaplaincy. A good introduction to professional healthcare chaplaincy can also be found in VandeCreek and Burton.[6]

Before proceeding we need to briefly define two key terms, spirituality and religion. Spirituality is about the ultimate sources of meaning in our lives and our connection with a transcendent dimension of existence. Religion refers to institutions in our culture that play an important role in the development of spirituality for many, but not all, people. For more about these terms see Chapter 59 in this volume and Miller and Thoresen.[7] Because chaplains deal with both religion and spirituality, in this chapter we refer to religion/spirituality (R/S).

WHO ARE PROFESSIONAL HEALTHCARE CHAPLAINS?

The term chaplain is often used in a broad sense to refer to any clergy, or other spiritual counselors, who work in institutional contexts such as hospitals. In the United States, the Joint Commission specifies that patients have a right to care that respects their "spiritual values," and requires a minimal spiritual assessment.[8] Regarding standards for hospital chaplains, Joint Commission guidelines simply state that "clinical chaplains," like other staff should be "qualified…by virtue of…education, training, experience, competence, registration, certification, or applicable licensure, law or regulation."[9] In the absence of more explicit external standards from organizations such as the Joint Commission, hospitals and other healthcare institutions are free to set their own requirements for the chaplains that work there. Consequently, in contrast to other professionals such as physicians or nurses, there can be considerable diversity in the basic training and qualifications of people who are called chaplains.

Some people who are called chaplains are congregational clergy who spend some or all of their time working in the context of a hospital, nursing home or hospice. Often their ministry focuses on people from their own religious tradition. Other people who are called chaplains are clergy who have had additional specialized training in healthcare ministry (e.g., CPE). In recent years the term Board Certified Chaplain (BCC) has emerged to indicate a person who in addition to this specialized training has demonstrated competence in healthcare ministry before a review board.

In North America, six major professional organizations are concerned with specialized ministries of pastoral care, pastoral counseling, and training. Recently these groups formed the Spiritual Care Collaborative (SCC) (The organizations that are part of the Spiritual Care Collaborative [SCC] include the Association of Professional Chaplains [APC], the American Association of Pastoral Counselors [AAPC], the Association for Clinical Pastoral Education, Inc. [ACPE], the National Association of Catholic Chaplains [NACC], the National Association of Jewish Chaplains [NAJC], and the Canadian Association for Pastoral Practice and Education [CAPPE]). In 2004, the groups in the SCC approved a common set of standards for professional chaplains. They also approved Common Standards for pastoral educators/supervisors, those who train healthcare chaplains, and a Common Code of Ethics.

The Common Standards for BCCs begin with endorsement and continued good standing with one's faith tradition. A second basic requirement is completion of both an undergraduate degree and a graduate-level theological degree. The third basic requirement is completion of four units of CPE accredited by one of the SCC groups.

Clinical pastoral education (CPE) is a distinctive form of preparation for professional spiritual care in that it is multifaith; CPE supervisors come from all major faith traditions, as do the students who form the training groups. CPE is also a very experiential form of education. A unit of CPE includes a total of 400 hours of work and 50%–75% of the students' time is usually spent in the supervised practice of spiritual care. In addition to their clinical practice, CPE students participate in didactic seminars and in a peer supervision group where they discuss verbatim or case reports of their clinical practice with their peers and supervisor. Four units of CPE are often completed as a spiritual care residency year. In some cases, students elect to complete a 2-year residency which permits additional training in a specialized area, such as care for patients with cancer and their families.

As noted earlier, chaplains who have faith group endorsement, a graduate theological degree, and at least four units of CPE are eligible to become BCC through one of the certifying groups in the SCC. The process of becoming a BCC includes submitting a written application that includes two reports of one's spiritual care, and an interview with a panel that includes other BCCs. Competencies that must be demonstrated in the application and interview include the ability to formulate a spiritual assessment and plan of care; the ability to provide effective spiritual support to patients and families; the ability to use appropriate religious or spiritual resources in care for patients and families; the ability to provide spiritual care in collaboration with other healthcare professionals; the ability to integrate relevant information from the behavioral sciences into spiritual care; and the ability to reflect on the ethical and theological issues involved in spiritual care.

A key ethical principle, to which BCCs must adhere is to "Demonstrate respect for the cultural and religious values of those they serve and refrain from imposing their own values and beliefs on those served" (Common Ethical Code, Principle 1.3). Casual observers may not be aware of how central this principle of respect for the religious values of others, and prohibition of any attempts to proselytize others, is for modern professional healthcare chaplaincy. Other core ethical principles include promoting the best interests of those served, safeguarding the confidentiality of those served, understanding the limits of one's expertise, and making referrals when appropriate. Part of what is unique about BCCs is the multiple ways in which they are accountable for their work. This begins with accountability to one's faith group which must be documented at the time of certification and every 5 years thereafter. It includes accountability to one's employer. Finally, BCCs must complete 50 hours of annual continuing education and a peer review every 5 years. In the next section we describe what professional healthcare chaplains do.

PROFESSIONAL HEALTHCARE CHAPLAINS—WHAT DO THEY DO?

Healthcare chaplains work in a variety of settings including hospitals, nursing homes, outpatient clinics, hospices, and free standing specialized healthcare settings (e.g., cancer, pediatrics). In most cases these organizations directly employ chaplains. In some cases chaplains work for their own faith group but have hospital privileges to minister to persons from their faith traditions. Infrequently chaplains are volunteers.

Chaplains provide direct R/S care and contribute to the ethos of care in healthcare organizations. Ideally, all healthcare providers provide some R/S care, perhaps by being open to the patient's R/S concerns and inquiring about them in an open, respectful manner. But chaplains usually have greater training and education in R/S care, focus more of their time providing R/S care, and address the more complex depths of a patient's/family member's R/S concerns.[10,11]

Much of a chaplain's work is at the bedside. Establishing a caring relationship with patients/families is primary. For many patients/families, a chaplain may offer empathic listening and faithful presence. Chaplains may represent a caring community or transcendence beyond the identity of the chaplain. Chaplains perform or help establish protocols for R/S screening so that they can better prioritize their ministries. This is important because few healthcare organizations have enough chaplains to see every patient. Chaplains perform R/S assessments that provide insight into the person of the patient, their R/S strengths and concerns, and guiding values that may inform treatment decisions. Chaplains nurture the R/S strengths of those for whom R/S is important, help patients explore R/S concerns, and provide guidance for those seeking to deepen their R/S. Chaplains assess and explore R/S distress that may be manifest or latent.[12–14] Regarding R/S assessment and R/S distress also see Chapter 59 in this book.

Chaplains provide rituals and sacraments. They help process grief regarding losses or potential losses and offer comfort, life review, and care. Chaplains also celebrate good news through words, prayers, or rituals. Chaplains help patients/families in transitions, for example when going home may be scary or when the prognosis is changing for the worse. Chaplains help facilitate communication within families and between patients/families and healthcare providers regarding fears, hopes, realistic prognosis, values, and goals.

One study indicated that chaplains may be even more important to families,[15] especially since families often receive less psychosocial support. Chaplains help patients and family members talk to one another about their common fears, their values regarding end-of-life preferences, the reality of a serious prognosis, and their lives together.[16]

Chaplains often facilitate groups. These might be on-going or term-limited support groups, R/S groups, bereavement groups, and so on. Chaplains also lead worship and meditation services, both on a regular basis and on special occasions.[16,17]

The chaplain may collaborate with representatives of local R/S communities regarding a specific patient or patient group. In some settings, there may be chaplains who primarily minister to patients from the chaplain's faith tradition. More commonly, in nonsectarian healthcare systems, chaplains function as interfaith chaplains, that is, they meet people where they are in their own R/S traditions, addressing broader spiritual issues. When more R/S specific needs are identified, the chaplain will refer to a representative from that tradition (e.g., for a Latter Day Saint blessing).

This raises the question of who really needs a chaplain. Some people are strongly connected to their home R/S community but are now far from home without that strong R/S support. Others have a strong connection with their home R/S community but their clergy may feel uncomfortable in hospital visitation or be overwhelmed with other duties. Many people are spiritual but have no faith community, no one with whom to talk about deeper spiritual issues. All of these persons may benefit from a relationship with a chaplain.

Chaplains function as part of the multidisciplinary team. Within the team, chaplains participate in dialogue about patients and their care, in patient rounds and specific care conferences, in consultation regarding a patient's R/S, and in debriefing and support within the team. Chaplains also chart in the health information/medical record, documenting R/S assessments, care plans, interventions, and outcomes.[6,18–20] But the team also serves the chaplain. Chaplains depend upon other staff for updates about a patient's status or family dynamics as well as for referrals. Enhanced R/S care depends upon staff screening for and engaging patients about R/S needs and appropriately referring to a chaplain.[12,14]

Staff care is another significant ministry for chaplains. This care ranges from informal conversations and relationship building to formal counseling around a personal or professional issue. Conversation topics might include cumulative or disenfranchised grief, the death of a particular patient, vocational discernment, values conflicts at work, work exhaustion and self-care, personal R/S journey, or family issues. Chaplains provide impromptu rituals for staff after the death of a patient, periodic memorial services for staff to remember patients who have died, or memorial services for a colleague who has died. Chaplains may provide rituals of appreciation such as hand blessings or Tea for the Soul.[21,22] Chaplains may provide situation-specific, term-limited staff support groups as well as in-services about various topics, for example, getting in touch with one's own R/S and understandings of death, finding soul at work, grief, self-care, R/S, and cultural diversity, and so on. Many believe that staff who feel appreciated and cared for, a value in its own right, tend to provide better care to their patients, take less sick leave, and stay longer in their jobs.[6,23,24]

Chaplains often contribute to a healthcare organization through participation on committees or other assigned responsibilities. These responsibilities include assisting patients/families with advance directives or in organ donation protocols, participating on ethics committees and consultation teams, providing bereavement care, building relationships with and helping educate local faith communities/clergy regarding S/R and health,[25] and educating about and navigating relationships within multicultural and R/S diversity.[6,26] Chaplains also provide another voice to uphold the ethics and conscience of the organization in the face of competing demands.

Chaplains are involved in ethics decisions formally and informally. Formally, chaplains participate on clinical ethics committees, clinical ethics consultation services, institutional review boards, and research ethics committees. Informally, one dimension of chaplaincy is helping patients/families sort through their values and their implications for healthcare decisions, for example, when to shift from aggressive treatment to comfort care.[6] These values are often rooted in their R/S or cultural tradition.

Chaplains often take the lead in providing care to bereaved families. This care can include follow-up cards or phone calls, providing information about grief and mourning, facilitating a short-term bereavement group, and/or leading memorial services to which families are invited.

CHAPLAINS AND CANCER CARE, PALLIATIVE CARE, HOSPICE

Currently there are no subspecialty certifications in chaplaincy. Either one is or one is not a BCC regardless of context or medical population served. However, some chaplains may have more specialized training in cancer care, palliative care, or hospice care than others. For example, a chaplain who completes a CPE residency in an acute care setting may complete a special project related to oncology chaplaincy. Other chaplains may complete their residency at a major cancer center, or a hospice, or pursue a second year residency/fellowship focusing on oncology, palliative care, and/or hospice.

What we have written above about who chaplains are and what they do also applies to oncology, palliative care, and hospice chaplains. But there are some differences. A diagnosis of cancer may create more fear than other diagnoses, and stimulate questions such as "Will I die from this?" or "How sick will the treatment make me?" or "Will my life ever be the same again?" Indeed, many cancer patients experience their world turned upside down without an adequate map to guide them.[27]

Chaplains in oncology, palliative care, and hospice often develop deep relationships that offer patients/families emotional support and comfort and permit in-depth exploration of important issues. These chaplains are very attentive to theological/existential themes such as hope, forgiveness, healing, finitude, and suffering, what and where is the sacred, the meaning of life, ethical wills (i.e., legacy, what one did and wants to pass on to loved ones), life review, death and how one's life does or does not continue beyond death.[17] Palliative care and hospice chaplains are typically well integrated into multidisciplinary teams, partially because it is mandated by hospice and palliative care standards.

Chaplains must be attentive to developmental issues, especially with children. Developmental stage, as well as culture, impacts personality, understandings of death, locus of safety, and specific concerns (e.g., missing the prom for an adolescent). Pediatric oncology chaplains take different approaches to their patients because of the major developmental differences in the first 18 years of life. Cancer may delay some developments and speed up others (e.g., the child who is "wise beyond her years"). As always, the chaplain must be in the moment; follow the lead of the child; be respectful, genuine, and, sometimes, playful.

With the exception of hospice chaplaincy, which is often home-based, most chaplaincies still occur in the inpatient setting. However, at a few major cancer centers chaplain departments have invested a significant portion of their staff resources to outpatient care. It is in the outpatient setting that patients often learn of a diagnosis or recurrence of disease, of change in prognosis, or of a major complication. The outpatient clinic may be the place where a patient hits the wall, emotionally and physically, after months of treatments, or comes to a place where they want to explore their R/S lives or other important concerns (e.g., relationships, stewardship of one's life, priorities).[28] Furthermore, because treatments are increasingly performed in outpatient settings and can extend over a long period of time, and because cancer in many cases has become a more chronic type of illness, when there is continuity between outpatient and inpatient settings, chaplains can develop long-term relationships that are supportive and often transformative.[29]

While chaplaincy all over the world has many characteristics in common, there are also important national differences in how chaplains are trained, hired, and integrated. We now turn to chaplaincy outside the United States. Since space does not permit us to describe chaplaincy in every part of the world we focus on healthcare chaplaincy in Europe. (For a series of articles about chaplains in countries outside of the United States see the archives of the "Advocacy" column in the chaplaincy e-newsletter, *Plain Views*' [www.plainviews.org], especially Volume 5, 2008. The website of the International Council for Pastoral Care and Counseling [ICPCC] [www.icpcc.net] also has links to chaplaincy networks around the globe. The ICPCC, and other international chaplaincy organizations, reflect a level of shared characteristics among healthcare chaplains across nations.)

CHAPLAINCY IN EUROPE

European chaplains would easily recognize themselves in the preceding description of what chaplains do in general and in the context of cancer and palliative care. Like their North American colleagues, European chaplains work in a variety of settings. The origins of chaplaincy in Europe are similar to those in the United States. Since the rise of Christianity in Europe there has always been some form of attending to the R/S needs of the sick. Countless Christian religious orders founded healthcare institutions where spiritual care was also offered.

As in the United States, changes in healthcare, and developments within theology, led to more professional chaplaincy in the second half of the previous century. In some European countries, like the United Kingdom, chaplains adapted the profession of pastoral counselor. In other countries, like the Netherlands, chaplains adapted the CPE model, but in ways that fit each national context. CPE in Austria, for example, is not part of chaplains' training. Rather, a 3-month unit is required within the first 3 years of employment. Other countries, like Belgium, have never adopted the CPE concept fully and developed their own version of supervision.

This example with CPE illustrates that education, training, and requirements for chaplains in Europe are very diverse. One can simply not talk about the same three basic requirements for European chaplains as exist for BCCs in the United States. Chaplaincy requirements differ by country. Among this great diversity, there are three essential factors that determine the contemporary settings for chaplaincy in each European country: its culture, its healthcare system, and its religious history. Instead of describing those factors for every one of the 27 countries that currently are members of the European Union; we outline the pattern in four major groups of nations.

The first group consists of countries, like Hungary, Bulgaria, or Romania, who struggle to develop professional chaplaincy due to political and economic issues. In these countries, historical, cultural, and healthcare factors are a hindrance in the training, hiring, and integrating of chaplains. Mostly these are European countries who were under a communist regime for a long time. They are still freeing themselves from an ideology that banned all R/S expression. Chaplains in these countries often find that people do not have a language with which to express their R/S needs, hopes, and resources. In these nations, chaplains not only face the lack of language and the gap in religious traditions, but also major financial shortcomings in their healthcare systems. Few chaplains are officially hired by healthcare institutions, and if they are, they can hardly survive.

The second group of countries include those who recently started developing professional chaplaincy and are growing strong. A good example would be Latvia. Latvia was occupied by the Soviet Union until 1990. Some years after the liberation, Lutheran Latvians living and working in the United States started training and funding Latvian Lutherans and Catholics to become chaplains. In 2004 Latvian chaplains participated for the first time in the consultation of the European Network for HealthCare Chaplaincy. In 2005 the Latvian Association for Professionals Chaplains was founded (http://www.lpvaka.lv/lpvaka-eng.html). The Association is a multifaith organization including chaplains from four denominations (the Russian Orthodox Church, the Baptist Church, the Lutheran and Catholic Church). Mostly young women, these Latvian chaplains face the challenge of low wages, low esteem among other healthcare professions, and a lack of supervisors and theological training. Despite their challenges they continue to grow strong as professional chaplains. Other countries in this group would include Estonia, Czech Republic,[30] and Slovakia.[31]

These first two groups were distinguished by where they are in the development of professional chaplaincy. The following two groups are defined by the faith traditions represented in their populations. European countries where one faith group is dominant form the third group. Most chaplains in these countries belong to the dominant faith group. Belgium, Spain, Portugal, Italy, and Austria are examples of countries where the vast majority of hospitals and chaplains are Catholic. The Northern countries like Finland, Denmark, Sweden, and Norway have mostly Protestant chaplains. If one faith group is dominant because the majority of the population belongs to that religious tradition, then multifaith spiritual care services are rare. Chaplains from the majority group generally visit everyone who requests their support or is referred to them. If a patient belongs to another faith group and desires to talk to someone from their tradition, the chaplain will do the necessary work to make that happen. Usually there is a good liaison between chaplains of the majority faith group and chaplains or representatives of minority faith groups. In most Western European countries the proportion of the population who attend church or hold church membership is diminishing. A growing group of people feel they are not affiliated with any

religious tradition. This phenomenon does not have a huge impact on the work of Catholic or Protestant chaplains. They visit those people as they always have and try to attend to their spiritual needs, hopes, and resources.

The last group consists of countries who opt for multifaith chaplaincy. The plural society in these countries leads to a need to include chaplains from non-Christian faith groups. The United Kingdom and the Netherlands would be two prime examples. (The Netherlands is also the only European country where representatives from humanism are called spiritual caregivers like their colleagues from religious traditions.) Multifaith chaplaincy in these countries is expressed in mixed teams in each healthcare settings (i.e., each hospital decides which faith groups will be represented). Not all European countries have national chaplaincy associations. In some countries chaplains are organized by denomination or diocese.

Although chaplaincies are organized very differently throughout the nations of Europe, chaplains do come together. The European Network of HealthCare Chaplaincy (ENHCC) gathers representatives of associations and faith groups every 2 years (http://www.eurochaplains.org). This organization was founded about 25 years ago when chaplains from several European countries felt the need to share their experiences. Out of that initiative the European Network was founded in 2000.

The European Network consists of representatives from churches, faith groups, and national associations. It is rooted in Christianity as expressed in European cultures but is open to representatives of other faith groups. During its biannual consultation the network aims to promote high standards for healthcare chaplaincy and to work for the development of professional guidelines required to minister to the spiritual and religious needs of patients, families, and staff. The Network has grown steadily in the number of participating countries and organizations. In recent years the European Network created liaisons with chaplaincy organizations in the United States and with the European Union in Brussels.[32]

During the 2008 consultation, 62 representatives from 23 European countries discussed end-of-life issues. Chaplains in Belgium and the Netherlands have to deal with legalized euthanasia while chaplains in Switzerland and the Netherlands also face legalized physician assisted suicide. Theological, ethical reflection, and case studies were enriching to all and were especially helpful to chaplains in countries facing the process of legalization of euthanasia.

The European Network respects the diversity in the way its members organize chaplaincy. Nevertheless it aims to work on common statements that will inspire and promote chaplaincy. In 2002 the European Network agreed on Standards for healthcare chaplaincy (http://www.eurochaplains.org/turku_standards.htm). The Standards are meant to be a point of reference and a guide for all faiths and denominations. In 2006 the Network agreed on Standards for palliative care (http://www.eurochaplains.org/lisbon06_palliative.doc). The Standards were inspired by the work done in the United Kingdom regarding the value and integration of spiritual care in palliative care (see the work of the Association of Hospice and Palliative Care Chaplains: http://www.ahpcc.org.uk/standards.html). Spiritual care in cancer care and palliative care is a priority to most European chaplains.

FUTURE CHALLENGES

Healthcare chaplaincy has been described as a professionalizing profession, which is a profession that is trying to strengthen its claim for a legitimate place in the healthcare world.[33] The key future challenges faced by healthcare chaplains are related to this process. They include becoming a research-literate and research-informed profession. Chaplains need to be able to read and understand research and learn to integrate insights from relevant research into their professional practice. Chaplains also need research, conducted by themselves or with professional colleagues, that evaluates spiritual care interventions in order both to improve those interventions and to demonstrate the effectiveness of their spiritual care.

Related to the need to become a research-informed profession, healthcare chaplains also need to develop standards for their practice.[34] Healthcare colleagues and the public need to be able to know what they may expect of trained and certified chaplains. For example, in most healthcare settings chaplains rely heavily on referrals to know where best to focus their limited attention.[35] Having clearer standards for their practice will enable chaplains to provide clearer guidelines to their healthcare colleagues about when they should make a referral to a chaplain. Currently consensus standards of practice for professional chaplains in acute care and long-term care are being developed in the United States.

There are several challenges for healthcare chaplains that are especially relevant for care for cancer patients and their families. One such challenge is expanding the contexts in which chaplains' services are available. With some exceptions, chaplains are not available in the outpatient context where many diagnoses are made and much of cancer treatment occurs.[29,36] In the United States, trained and certified healthcare chaplains are also more likely to be found at larger, urban, teaching hospitals.[37,38] Cancer patients and their families who receive treatment in other contexts are less likely to have access to a chaplain. In light of this, consideration should be given to increasing the number of creative training programs that help clergy and other spiritual counselors become more familiar with and comfortable in addressing the R/S issues faced by cancer patients and their families.[25]

From the time of diagnosis, through difficult treatment, and, in some cases, at the end of life, living with cancer often raises R/S issues for cancer patients and their families. Certified chaplains are members of the healthcare team who have the training and expertise to help cancer patients and their families address these issues and to provide R/S care in this difficult time.

REFERENCES

1. Asquith GH Jr. (ed.) *Vision from a little known country: A Boisen reader.* Decatur, GA: Journal of Pastoral Care Publications, Inc.; 1992.
2. Hall CE. *Head and heart: The story of the clinical pastoral education movement.* Decatur, GA: Journal of Pastoral Care Publications, Inc.;1992.
3. Dicks RL. The work of the chaplain in a general hospital. *Caregiver J.* 1940/1996;12(1):2–5.
4. Peachey K, Phillips CD. The college of chaplains: the first twenty-five years. *Caregiver J.* 1996;12(1):6–17.
5. Montefalcone WR. General hospital chaplaincy. In: R Hunter, (ed). *Dictionary of pastoral care and counseling*, Expanded ed. Nashville, TN: Abingdon Press; 2005:456–457.
6. VandeCreek L, Burton L. Professional chaplaincy: its role and importance in healthcare. *J Pastoral Care.* 2001;55(1):81–97.
7. Miller WR, Thoresen CE. Spirituality, religion, and health: an emerging research field. *Am Psychol.* 2003;58(1):24–35.
8. Joint Commission. Evaluating your spiritual assessment process. *Source.* 2005;3(2):6–7.
9. Joint Commission. *Comprehensive accreditation manual for hospitals: The official handbook.* Oakbrook Terrace, IL: Joint Commission Resources, 2008:GL-20.
10. Gordon T, Mitchell D. A competency model for the assessment and delivery of spiritual care. *Pall Med.* 2004;18:646–651.
11. Koenig HG. *Spirituality in patient care: Why, how, when, and what.* 2nd ed. Philadelphia, PA: Templeton Foundation Press; 2007.
12. Fitchett G. Screening for spiritual risk. *Chaplaincy Today.* 1999a;15(1):2–12.
13. Fitchett G. Selected resources for screening for spiritual risk. *Chaplaincy Today.* 1999b;15(1):13–26.
14. Fitchett G, Risk JL. Screening for spiritual struggle. *J Pastoral Care Counsel.* 2009 Aug;[Online] 63:1,2.
15. VandeCreek L, Lyons M. Ministry of hospital chaplains: patient satisfaction. *J Health Care Chaplain.* 1997;6(2).
16. Goodell E. Cancer and family members. *J Health Care Chaplain.* 1992; 4(1–2):73–85.
17. Handzo G. Where do chaplains fit in the world of cancer care? *J Health Care Chaplain.* 1992;4(1–2):29–44.
18. Ruff RA. "Leaving footprints": The practice and benefits of hospital chaplains documenting pastoral care activity in patients' medical records. *J Pastoral Care.* 1996;50(4):383–391.
19. Sakurai MLD. JCAHO and spiritual care: an invitation for chaplains to educate and advocate. *Vision.* 2000;10(3):6–7.
20. Sakuari M, Tartaglia A, Waff R. JACHO, JCAPS, and pastoral care: significant changes. *Chaplaincy Today.* 1998;14(2):52–56.
21. Brown S. *A blessing of the hands service.* Plain Views. 2008 June 18;5(10). http://www.plainviews.org. Accessed August 17, 2009.

22. Cummings MH. *Random acts of tea.* Plain Views. 2008 April 16;5(6). http://www.plainviews.org. Accessed August 17, 2009.
23. Sharp CG. Use of the chaplaincy in the neonatal intensive care unit. *South Med J.* 1991;84(12):1482–1486.
24. King SD, Jarvis D, Cornwell M. Programmatic staff care in an outpatient setting. *J Pastoral Care Counsel.* 2005;59(3):263–273.
25. Campbell D, Baile W, Galloway A. Advanced training for clergy in psychological oncology: program objectives, curriculum, and evaluation. *CareGiver J.* 1992;9(2–3):71–79.
26. Wilson-Stronks A, Galvez E. *Hospitals, language, and culture: A snapshot of the nation. Exploring cultural and linguistic services in the nation's hospitals. A report of findings.* Oak Brook Terrace, IL: The Joint Commission; 2007.
27. Frank A. *The wounded storyteller: Body, illness, and ethics.* Chicago, CA: The University of Chicago Press; 1995.
28. Samson A, Zerter B. The experience of spirituality in the psycho-social adaptation of cancer survivors. *J Pastoral Care Counsel.* 2003;57(3):329–343.
29. King SD, Jarvis D, Schlosser-Hall A. A model for outpatient care. *J Pastoral Care Counsel.* 2006;60(1–2):95–107.
30. Opatrna M. Why spiritual care in the Czech healthcare system? *Diagnoza v osetrovatelstvi.* 2006;3:105–108.
31. Nadova L, Prasilova M. *Why is it an advantage to have a chaplain in the institution (hospital/hospice)?* Proceedings of the Third International Conference on Hospice and Palliative Care. Trnava: Slovakia; 2005.
32. Vandenhoeck A. *A challenge for the European network of healthcare chaplaincy.* PlainViews. 2005. www.plainviews.org/v2n20/a.html.
33. DeVries R, Berlinger N, Cadge W. Lost in translation: Sociological observations and reflections on the practice of health care chaplaincy. *Hastings Cenr Rep,* 2008:38(6):23–27.
34. Mohrmann ME. Ethical grounding for a professional of hospital chaplaincy. *Hastings Cent Rep,* 2008;38(6):18–23.
35. Galek K, Flannelly KJ, Koenig HG, Fogg SL. Referrals to chaplains: the role of religion and spirituality in healthcare settings. *Ment Health Religion Cult.* 2007;10(4):363–377.
36. Anderson H, Holst LE, Sunderland RH. *Ministry to outpatients: A new challenge in pastoral care.* Minneapolis, MN: Augsburg Press; 1991.
37. Cadge W, Freese J, Christakis NA. The provision of hospital chaplaincy in the United States: a national overview. *South Med J.* 2008;101(6):626–630.
38. Flannelly KJ, Handzo GF, Weaver AJ. Factors affecting healthcare chaplaincy and the provision of pastoral care in the United States. *J Pastoral Care Counsel.* 2004;58(1–2):127–130.